Health Insurance Portability and Accountability Act of 1996

(HIPAA)

- **President Clinton signed into law the HIPAA on August 21, 1996.**

- **What does the act do for long term care insurance?**

  The Act states that long term care insurance will be treated in the same manner as health and accident insurance is treated under the Federal Income Tax Code.

  This means that *Benefits* paid by a policy will **not** be counted as taxable income to the policyholder; and *Premiums* paid for "tax qualified" policies can be counted as a non-reimbursed medical expense for those itemizing their deductions for federal income tax purposes.

- **Does the act apply to all long-term care insurance policies?**

  NO. The Act's provisions only apply to what the Act defines as "Qualified Long Term Care Insurance Contracts."

  A "Tax Qualified" policy is:

  Any policy issued **prior to January 1, 1997**. These policies are grandfathered under the Act. For group policies, if the master policy was issued prior to 1997, then it is grandfathered. This means all certificates issued under the group policy, even after January 1, 1997, would be considered tax qualified certificates (as long as the master policy does not change to add additional benefits; see **last point** in document).

  Policies issued **after January 1, 1997** must meet a set of standards described in the Act in order to be "Tax Qualified" policies. This has resulted in most, if not all, insurance companies revising and re-filing their policies for Indiana Department of Insurance approval.

- **How are employers treated under the Act?**

  Premiums paid by an employer for a "Tax Qualified" policy will be deductible from the employer's federal income tax. However, long term care insurance *cannot* be included as part of an employer's cafeteria benefits plan or flexible spending arrangement.

- **Can an individual take all of the premium as a tax deduction?**

  NO. The Act provides the following schedule for how much of the insurance premium can be applied as an unreimbursed medical expense for the Federal tax purposes:

Attained age before the close of the 2003 taxable year	Premium Limitation
40 or less	$250
41-50	$470
51-60	$940

61-70	$2,510
71 and older	$3,130

Individuals can use their actual premium amount up to the limitation noted in the chart. The Premium Limitation amounts will be increased annually by an amount equal to the medical care cost component of the Consumer Price Index.

For **self-employed**, the deduction is the same as any other health insurance. If the business paid the premium, then the deduction for tax year 2003 is 100%. *(Eligible premium is the actual insurance premium subject to the age limits in the chart above. Example: If the premium paid during 2003 was $600 and the individual was 45, the 100% deduction would apply to the maximum limit allowed for a 45 year old which is $450. Therefore, $450 would be the deduction.)*

- **What does the tax deduction really mean?**

  The deduction under the Act **is not a straight tax deduction**. In order to benefit from the tax deduction, an individual must:

  Itemize their deductions and have an amount of non-reimbursed medical expenses that **exceeds** 7.5% of their Adjusted Gross Income. The amount a person can use for a deduction is the amount exceeding the 7.5% figure.

- **When can someone start taking the deduction?**

  The deduction is effective starting with premiums paid in calendar year 1997.

- **How are out-of-pocket long term care expenses treated under the Act?**

  Payments made for "Qualified" long term care services, as defined in the Act, can be counted as an unreimbursed medical expense for federal income tax purposes. Therefore, co-payments and deductibles paid by an individual out of their own resources can be counted towards the 7.5% figure noted above.

- **What are the major differences between tax qualified policies and non-tax qualified policies?**

  The major differences found in tax qualified policies consist of changes to the benefit triggers, the addition of an *offer* of a nonforfeiture benefit, and the prohibition of these policies paying benefits at the same time as Medicare is paying benefits. This latter point includes the prohibition of policies paying benefits to cover the Medicare co-payments.

  In addition, services received must be "qualified long term care services" required by a "chronically ill individual" and are provided according to a plan of care prescribed by a licensed health care practitioner.

- **What are "qualified long term care services?"**

  The Act defines these services as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative services, and maintenance or personal care services.

- **What are the benefit triggers in tax qualified policies?**

Under the Act, benefit triggers are used as a means of defining when the policyholder is considered a "chronically ill individual." *Note: Medical necessity is no longer an allowable benefit trigger.* Benefit triggers are:

Activities of daily living (ADL) trigger - The individual is unable to perform (without "substantial assistance" from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity. Activities of daily living are: bathing, continence, dressing, eating, toileting, transferring. At least 5 ADLs must be used in tax-qualified policies. *Tax Qualified Indiana Partnership policies must use a 2 of 6 ADL trigger.*

Cognitive Impairment - The individual requires "substantial supervision" to protect such individual from threats to health and safety due to "severe" cognitive impairment.

The individual must be re-certified annually as being a chronically ill individual.

- **In the ADL trigger, what is meant by "for a period of at least 90 days?"**

  The 90 days are *not* a requirement for a 90-day elimination period. The licensed health care practitioner who is prescribing a plan of care must certify the person meets the ADL trigger now and will continue to meet the trigger for the next 90 days. If the person is certified as needing care for at least 90 days, then his/her health improves dramatically and is discharged from care prior to 90 days, the person is *not* penalized for the licensed health care practitioner's error in judgment.

- **In the ADL trigger, what is meant by "substantial assistance?"**

  According to Interim Guidance issued by the U.S. Department of Treasury, May 1997, substantial assistance means both hands-on and standby assistance. Hands-on assistance means the physical assistance of another person without which the individual would be unable to perform the ADL. Standby assistance means the presence of another person within arm's reach of the individual which is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

- **In the cognitive impairment trigger, what is meant by "substantial supervision" and "severe" cognitive impairment?**

  Interim Guidance, May 1997, states substantial supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the individual from threats to his/her health or safety. Severe cognitive impairment means a loss or deterioration in intellectual capacity that is (a) comparable to Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory; orientation as to person, place, or time; and deductive or abstract reasoning.

- **What are "Safe Harbors"?**

  Interim Guidance, May 1997, established "safe harbors" for insurance companies when first refiling a tax qualified policy. Companies which issued policies prior to 1997 using ADL or cognitive impairment triggers, may use the standards from these policies when determining how a trigger is met (defining "needs assistance with", "needs hands-on assistance," "needs direct assistance") in their new tax qualified policies. As a result, companies have the choice, when filing tax qualified policies, of

either using the new definitions for "substantial assistance, substantial supervision, and severe cognitive impairment" or the definitions they used in their pre-1997 policies. (Odds are high safe harbors will be eliminated upon the development of regulations by the U.S. Department of Treasury.) The remainder of the requirements under the Act must still be met (i.e. using at least 2 of 5 out of a list of 6 ADLS, 90 day certification by a licensed health care practitioner).

- **Do benefits received from non-tax qualified policies count as taxable income?**

  No one knows. The U.S. Department of Treasury may *not* define a non-tax-qualified policy in the first regulation. They consider the process of defining such a policy as being complicated, and are unsure as to whether they have the authority to do so.

- **If a policyholder owns a grandfathered tax qualified policy, and decides to add additional benefits to the policy later, will it retain its favorable tax status?**

  Interim Guidance, May 1997, states the answer is no. Any material change made to a grandfathered policy will cause it to lose its favorable tax status. The following exceptions are not treated as a material change: (a) a policyholder's exercise of any right provided under the terms of the contract as in effect on 12-31-96, or a right required by applicable state law to be provided to the policyholder, (b) a change in the mode of premium payment (for example a change from monthly to quarterly premiums), (c) in the case of a policy that is guaranteed renewable, a classwide increase or decrease in premiums, (d) a reduction in premiums due to the purchase of a long term care insurance policy by a family member of the policyholder, (e) a reduction in coverage (with a corresponding reduction in premiums) made at the request of a policyholder, (f) the addition, without an increase in premiums, of alternative forms of benefits that may be selected by the policyholder, (g) the addition of a rider (including any similarly identifiable amendment) to a policy issued prior to 1-1-97 in any case in which the rider, if issued as a separate contract of insurance, would itself be a tax-qualified long term care insurance contract, (h) the deletion of a rider or provision that prohibited coordination of benefits with Medicare, and (i) the effectuation of a continuation or conversion of coverage right provided under a group contract following an individual's ineligibility for continued coverage under the group contract.